Community Hospital Task Force II
Meeting #1 Notes
November 19, 2007
Department of Administration - Conference Room A
Providence, RI

The Task Force co-chairs, Director of Human Services, Gary Alexander, and Health Insurance Commissioner, Christopher Koller, convened the task force meeting at 5:05 pm. Koller welcomed the task force back to the table and asked the members to introduce themselves. Staff at the meeting also introduced themselves to the task force.

> **Goal of 1st Meeting**: Review findings from the first task force and explain the charge and process for next phase of the task force. Set common expectations for short-term and long-term objectives. Review and build understanding of the current hospital reimbursement system for Medicaid Fee for Service

Welcoming Remarks (Governor Carcieri and Lt. Governor Roberts)

- Governor Carcieri welcomed the task force members and thanked them for their previous work.
    - Discussed the importance of focusing on Medicaid as a standard to allow the conversation to broaden to all reimbursement.
    - Asked the task force to move away from budgetary discussions toward developing principles for a system of compensation that can provide reliable and rationalized reimbursement to community hospitals.
- Lieutenant Governor Roberts also thanked the task force for their commitment to spending the upcoming weeks working very hard under a short time frame.
    - Encouraged the task force to think about a reimbursement system that supports the mission of the Community Hospitals to provide high quality, accessible care that their communities need.

Review Task Force's initial findings and new charge to Community Hospital Task Force (Koller)

Commissioner Koller discussed the new charge for the task force.

> **Charge:** Using its initial findings on community hospitals, the Community Hospital Task Force will address one of its two earlier recommendations: payment reform. The long-term charge to the Task Force is to recommend changes to health care payment methods used by all payers that realign incentives to promote high-quality and cost-efficient care. The Task Force's first priority is to examine principles for inpatient payment and options for Rhode Island's Medicaid program to implement a case-based inpatient payment methodology based on Medicare. The Task Force will then examine how the recommendations for a case-based inpatient payment method for Rhode Island Medicaid may apply more broadly to other payers.

Commissioner Koller explained the timeline for the task force

- Expectation that the recommendations of the task force for Medicaid reimbursement policy will be included in the Governor's Budget to be submitted in late January.
- First report will be completed by January 10, 2008 and the goal is for that report to include the consensus decision of the task force for the recommended reimbursement system for Medicaid. If consensus cannot be reached, the report will include the principles of reimbursement that the group agrees to and a description of the discussion surrounding the payment methods.
- Second report will be recommendations for changes to the methods that commercial insurers use to reimburse hospitals. The report would be issued in March 2008.

Commissioner Koller explained that meetings from now through the issuance of the first report would be dealing solely with the principles and methodology for Medicaid inpatient hospital reimbursement.

Process for accomplishing Task Force work (Director Alexander)

Director Alexander reviewed the meeting schedule and goals (Attachment #5)

Task Force member discussion on charge and process

- Comments from Task Force members
    - Methodology should be independent of Disproportionate Share
    - The charge of the task force appears to be, at least in part, to create a consistent reimbursement method across Medicaid and commercials insurers. If that is the case, why not combine the discussions instead of separating and sequencing them?
    - Outpatient procedures are pulling money away from hospitals and the issue needs attention.
        - Commissioner Koller informed the task force that in Rhode Island 45% of hospital reimbursements are inpatient payments and 55% are outpatient payments. While the percentage of payments from outpatient procedures are increasing, they are increasing at a lower rate than in most states.
    - What will need to be done to implement changes that the task force recommends? The current Medicaid inpatient reimbursement system is set in statute, so any changes would require, at the minimum, that the current statutory language be repealed to permit an alternative methodology. Additionally, a state plan amendment would need to be filed with CMS.
    - An examination of the methodologies for outpatient reimbursements in different states should be undertaken as part of the deliberations of this group.
    - What is happening with the other task force recommendation on collaboration and regulatory changes? The Department of Health is putting together an informational document that describes the current regulatory process, focusing on certificate of need. Health will then hold a public meeting to discuss potential changes. The Department hopes to have this meeting in early December.
    - There are a number of issues that affect hospitals' financial situations, including commercial insurers reimbursement levels, uneven Medicaid and Medicare funding levels, freestanding outpatient clinics, uncompensated care and physician reimbursement. All of these issues will need to be addressed in the future.
    - Governor Carcieri stated that the state cannot sustain the current levels of inflation of health care costs. The state's budget issues require a change and that's what the task force will be doing.

Current Medicaid payment for inpatient stays (Ralph Racca, Department of Human Services)

Using Attachment #6, Racca described the current process for inpatient stays - Medicaid reimburses hospitals for a percent of their charges for services provided. The charges are based on rates negotiated by DHS with hospitals on an annual basis. These negotiated rates are capped by a statutory limit known as the "MAXICAP." DHS determines a hospital's costs through a year-end settlement process which reviews payments made for procedures by DHS against services provided by the hospital.

- Points brought up by Task Force
    - Settlement Process is not up-to-date. Some hospitals are potentially 10-12 years behind in the settlement process, and therefore, there is not a good assessment of some hospital's costs. There was some divergence among members as to how long some of the time gaps in the reconciliation process are - range in the discussion was from 1-2 years to 10-12 years and Mr. Racca reported that timely compliance has been improving.
    - DHS considers regular fee for service inpatient and NICU payments separately. Should the task force consider these together?
    - If the task force recommended that DHS move to a DRG system, would there still be a

year-end settlement process? Racca said that there would be a year-end procedure, but that it would resemble an audit to ensure no overages according to federal guidelines rather than a settlement as in the current system.

- Dr. Gifford explained the back page of Attachment #4 that describes the variance in payments to community hospitals for the same services over the different types of payers. Among the 4 major payer systems Medicaid exhibits the greatest variance between hospitals for the same services.

Public Comment

There was no public comment.

Meeting Adjournment

Commissioner Koller adjourned the meeting at 6:30pm. The next meeting will be held Tuesday, November 27, 5:00pm at Quality Partners of RI, 235 Promenade Street, Providence.